STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155072	A. BUILDING 00 B. WING	09/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEECH GROVE MEADOWS	2002 ALBANY ST BEECH GROVE, IN46107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00097362. Complaint IN00097362 - Substantiated. Federal/state deficiencies related to the allegation are cited at F225 and F226. Survey dates: September 23 & 26, 2011 Facility number: 000029 Provider number: 155072 AIM number: 100275200 Survey team: Joyce Hofmann, RN Census bed type: SNF: 18 SNF/NF: 105 Residential: 14 Total: 137 Census payor type: Medicare: 21 Medicaid: 75 Other: 41 Total: 137 Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0225 SS=D	Quality review 9/30/11 by Suzanne Williams, RN The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to ensure	F0225	**F 225 Investigate/Report Allegations/Individuals** This	10/05/2011

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	all alleged violations of abuse were reported immediately to the Administrator of the facility, for 1 of 3 residents reviewed for allegations of abuse in a sample of 3. [Resident #B] Findings include: Interview with the Administrator on 09/23/11 at 1:35 p.m. indicated no allegations of abuse had been reported to him in the last 24 hours. Interview with CNA #1 on 09/23/11 at 3:02 p.m. indicated he was afraid residents were being sexually abused by CNA #2, and indicated this was not the first allegation of abuse with CNA #2. Other co-workers had said this was the last hallway CNA #2 could work on. CNA #1 explained the first allegation was when a resident got upset when CNA #2 asked the resident to rub his genital area, and the second allegation was a different resident who alleged the same and made the resident feel uncomfortable due to his sexual advances. CNA #1 did not indicate when these two incidents occurred. CNA #1 alleged CNA #3 had told him about bruising when RN #1 tried to straight cath Resident #B for a urine specimen, and CNA #3 was assisting the RN at the time. CNA #1 indicated he did not have any contact with Resident #B that evening or		provider ensures that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The aide in question was suspended pending investigation to ensure the safety of residents. The employee who did not report the allegation of abuse was suspended pending investigation for failure to report alleged abuse. The employee who did not report the allegation of abuse was eventually terminated for not following our reporting policy. A vaginal assessment and interview of the resident by DNS and Surveyor completed. No injuries noted. Resident denied pain or discomfort. Family and Physician notified of the allegation and that the facility was investigating. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** Residents that reside in the facility are at risk for the alleged deficient practice. Customer care reps make daily	

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	with CNA #2, even though they worked the same shift the evening of the alleged incident. CNA #1 denied having any disagreements or animosities going on between himself and CNA #2. CNA #1 explained CNA #2 was the aide taking care of Resident #B and numerous other women on the hall. CNA #1 explained he did not go to the Administrator or follow the chain of command, because he did not think the administrative staff would do anything about the situation. Interview with CNA #2 on 09/23/11 at 3:30 p.m. indicated he had been a CNA for 2 1/2 years. CNA #2 indicated he worked with Resident #B and also worked with CNA #1. CNA #2 indicated he did not know CNA #1 other than through work and did not know him well. The employee record form indicated CNA #2 worked at the facility since 04/10/10 and CNA #1 had worked at the facility since 08/10/11. Interview with the Administrator and Director of Nursing [DON] on 09/26/11 at 2 p.m. indicated there were two other incidents with CNA #2 which both happened on 07/15/11 and both investigated. The first incident was with a male resident who was end stage Parkinson's with lower extremity contractures and end stage dementia. The		rounds to each resident to inquire about how things are and if they are comfortable with care they receive. **What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.** · Staff was inserviced on 9/23/11-9/26/11 by DNS and Staff Development Coordinator regarding abuse policies, with emphasis placed on reporting any allegation of abuse to the DNS and Executive Director immediately. · In addition, stressed to staff that it is their obligation to follow reporting procedures and that failure to do so would result in termination as well as possible loss of their license and ability to work in the Healthcare industry. Customer care reps make daily rounds to each resident to inquire about how things are and if they are comfortable with care they receive if anything is identified during rounds a thorough investigation of the allegation will be conducted by the ED or designee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. CQI tool “Abuse Prohibition and Investigation” will be completed randomly on all shifts weekly times 4, monthly times 2, and quarterly x 2. If deficiencies	

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	resident had dry skin in his scrotal area and staff were applying lotion and preventative creams during incontinence care. The resident needed two staff to provide care due to the contractures and while providing care, the resident thought they touched him inappropriately. The resident's roommate and spouse were in the room and did not voice any concern or complaint. A head to toe assessment was completed with no injury. Staff involved were immediately removed from the care of the resident. The Social Service Director met with the resident and found no distress or recollection of concern upon interview the same evening. Communication techniques were explained to the staff involved. Explanation provided that all communication should be in language, format, volume easily understood by the resident being cared for. The second incident involved a female resident who was confused and had delirium. The resident was noted to have an abscess or boil to her groin area. The resident alleged the aides made comments which were upsetting to her, but no inappropriate contact. The staff were immediately removed from her care. The two aides involved had been employed for 2 years at the facility and had no resident complaints. Social Service Director		noted, an action plan will be developed and implemented. DNS or designee is responsible for monitoring compliance. Any findings will be brought to the QA team on a monthly basis.	

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	interviewed the resident immediately and noted changes and inconsistencies in speech and details. Social Services met with the resident and found no distress or recollection of concern upon interview the same evening. Interview with RN #1 on 09/23/11 at 2:14 p.m. indicated she did straight cath Resident #B for an urine specimen on night shift 09/22/11 and at first could not find the correct opening for the catheter. RN #1 indicated she went and got a second catheter and laid the resident on her side and was able to get the urine sample. RN #1 indicated right where you go in with the catheter was a little purple and didn't know if the resident was prolapsing or what, as it was harder than normal to find. RN #1 indicated there was no vaginal tears, no bleeding, but just harder than normal to find the right place. RN #1 indicated she had CNA #3 in the room with her during the urine specimen collection. RN #1 indicated she did not report this to anyone. Interview with CNA #3 on 09/23/11 at 2:55 p.m. indicated she worked last night and was in the room with RN #1 to collect the urine specimen. CNA #3 indicated she noticed the area being bruised, colored purple. CNA #3 indicated the nurse could not get the urine sample the			

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	first try and had to try again and turned the resident on her side. CNA #3 indicated she told the resident to hold her hand and if it hurt she could squeeze her hand. CNA #3 indicated she squeezed her hand. CNA #3 indicated she and the nurse discussed the color of the resident's private area and the nurse was to report it to the Director of Nursing [DON] and the unit manager. CNA #3 denied telling anyone about the situation. During observation on 09/23/11 at 2 p.m., Resident #B was examined by the DON and nothing unusual was found. The resident at this time denied anyone hurting her down there. Review of Resident #B's clinical record on 09/23/11 at 2:50 p.m. indicated on the most recent significant change Minimum Data Set [MDS] assessment dated 09/23/11, the resident was severely cognitively impaired with daily decision making-skills and confused. A Physician Telephone Order dated 09/21/11 indicated an order for an urinalysis with culture and sensitivity due to increased agitation and confusion. Nurse's notes dated 09/23/11 at 0130 [1:30 a.m.] indicated, "...U/A [urinalysis] collected and sent...." The facility's Abuse Prohibition, Reporting, and Investigation Policy and			

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	Procedure dated February 2010 was reviewed on 09/26/11 at 11 a.m. indicated, "... All abuse allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative (sponsor, responsible party) within 24 hours of the report. Failure to report will result in disciplinary action, up to and including immediate termination...." This federal deficiency is related to Complaint IN00097362. 3.1-28(c)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to implement their policy and procedures that prohibit alleged abuse, related to allegations not being immediately reported to the Administrator, for 1 of 3 residents reviewed for abuse in a sample of 3. [Resident #B] Findings include: Interview with the Administrator on 09/23/11 at 1:35 p.m. indicated no	F0226	**F 226 Develop/Implement Abuse/Neglect, etc Policies** This provider ensures that written policies will be implemented and developed that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The aide in question was	10/05/2011

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	allegations of abuse had been reported to him in the last 24 hours. Interview with CNA #1 on 09/23/11 at 3:02 p.m. indicated he was afraid residents were being sexually abused by CNA #2, and indicated this was not the first allegation of abuse with CNA #2. Other co-workers had said this was the last hallway CNA #2 could work on. CNA #1 explained the first allegation was when a resident got upset when CNA #2 asked the resident to rub his genital area, and the second allegation was a different resident who alleged the same and made the resident feel uncomfortable due to his sexual advances. CNA #1 did not indicate when these two incidents occurred. CNA #1 alleged CNA #3 had told him about bruising when RN #1 tried to straight cath Resident #B for a urine specimen, and CNA #3 was assisting the RN at the time. CNA #1 indicated he did not have any contact with Resident #B that evening or with CNA #2, even though they worked the same shift the evening of the alleged incident. CNA #1 denied having any disagreements or animosities going on between himself and CNA #2. CNA #1 explained CNA #2 was the aide taking care of Resident #B and numerous other women on the hall. CNA #1 explained he did not go to the Administrator or follow the chain of command, because he did not		suspended pending investigation to ensure the safety of residents. The employee who did not report the allegation of abuse was suspended pending investigation for failure to report alleged abuse. The employee who did not report the allegation of abuse was eventually terminated for not following our reporting policy. A vaginal assessment and interview of the resident by DNS and Surveyor completed. No injuries noted. Resident denied pain or discomfort. Family and Physician notified of the allegation and that the facility was investigating. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** Residents that reside in the facility are at risk for the alleged deficient practice. Customer care reps make daily rounds to each resident to inquire about how things are and if they are comfortable with care they receive. **What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.** · Staff was inserviced on 9/23/11-9/26/11 by DNS	

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	think the administrative staff would do anything about the situation. Interview with CNA #2 on 09/23/11 at 3:30 p.m. indicated he had been a CNA for 2 1/2 years. CNA #2 indicated he worked with Resident #B and also worked with CNA #1. CNA #2 indicated he did not know CNA #1 other than through work and did not know him well. The employee record form indicated CNA #2 worked at the facility since 04/10/10 and CNA #1 had worked at the facility since 08/10/11. Interview with the Administrator and Director of Nursing [DON] on 09/26/11 at 2 p.m. indicated there were two other incidents with CNA #2 which both happened on 07/15/11 and both investigated. The first incident was with a male resident who was end stage Parkinson's with lower extremity contractures and end stage dementia. The resident had dry skin in his scrotal area and staff were applying lotion and preventative creams during incontinence care. The resident needed two staff to provide care due to the contractures and while providing care, the resident thought they touched him inappropriately. The resident's roommate and spouse were in the room and did not voice any concern or complaint. A head to toe assessment was		and Staff Development Coordinator regarding abuse policies, with emphasis placed on reporting any allegation of abuse to the DNS and Executive Director immediately. · In addition, stressed to staff that it is their obligation to follow reporting procedures and that failure to do so would result in termination as well as possible loss of their license and ability to work in the Healthcare industry. Customer care reps make daily rounds to each resident to inquire about how things are and if they are comfortable with care they receive if anything is identified during rounds a thorough investigation of the allegation will be conducted by the ED or designee. All investigations of allegations of abuse, neglect or misappropriation of property will be reported within 24 hours to ISDH. All investigations will be thoroughly investigated by ED/DNS within 5 days of the incident. How the corrective action(s) will be monitored to ensure the	

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	completed with no injury. Staff involved were immediately removed from the care of the resident. The Social Service Director met with the resident and found no distress or recollection of concern upon interview the same evening. Communication techniques were explained to the staff involved. Explanation provided that all communication should be in language, format, volume easily understood by the resident being cared for. The second incident involved a female resident who was confused and had delirium. The resident was noted to have an abscess or boil to her groin area. The resident alleged the aides made comments which were upsetting to her, but no inappropriate contact. The staff were immediately removed from her care. The two aides involved had been employed for 2 years at the facility and had no resident complaints. Social Service Director interviewed the resident immediately and noted changes and inconsistencies in speech and details. Social Services met with the resident and found no distress or recollection of concern upon interview the same evening. Interview with RN #1 on 09/23/11 at 2:14 p.m. indicated she did straight cath Resident #B for an urine specimen on		deficient practice will not recur, i.e., what quality assurance program will be put into place. CQI tool "Abuse Prohibition and Investigation" will be completed randomly on all shifts weekly times 4, monthly times 2, and quarterly x 2. If deficiencies noted, an action plan will be developed and implemented. DNS or designee is responsible for monitoring compliance. Any findings will be brought to the QA team on a monthly basis.	

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	night shift 09/22/11 and at first could not find the correct opening for the catheter. RN #1 indicated she went and got a second catheter and laid the resident on her side and was able to get the urine sample. RN #1 indicated right where you go in with the catheter was a little purple and didn't know if the resident was prolapsing or what, as it was harder than normal to find. RN #1 indicated there was no vaginal tears, no bleeding, but just harder than normal to find the right place. RN #1 indicated she had CNA #3 in the room with her during the urine specimen collection. RN #1 indicated she did not report this to anyone. Interview with CNA #3 on 09/23/11 at 2:55 p.m. indicated she worked last night and was in the room with RN #1 to collect the urine specimen. CNA #3 indicated she noticed the area being bruised, colored purple. CNA #3 indicated the nurse could not get the urine sample the first try and had to try again and turned the resident on her side. CNA #3 indicated she told the resident to hold her hand and if it hurt she could squeeze her hand. CNA #3 indicated she squeezed her hand. CNA #3 indicated she and the nurse discussed the color of the resident's private area and the nurse was to report it to the Director of Nursing [DON] and the unit manager. CNA #3 denied telling			

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	anyone about the situation. During observation on 09/23/11 at 2 p.m., Resident #B was examined by the DON and nothing unusual was found. The resident at this time denied anyone hurting her down there. Review of Resident #B's clinical record on 09/23/11 at 2:50 p.m. indicated on the most recent significant change Minimum Data Set [MDS] assessment dated 09/23/11, the resident was severely cognitively impaired with daily decision making-skills and confused. A Physician Telephone Order dated 09/21/11 indicated an order for an urinalysis with culture and sensitivity due to increased agitation and confusion. Nurse's notes dated 09/23/11 at 0130 [1:30 a.m.] indicated, "...U/A [urinalysis] collected and sent...." The facility's Abuse Prohibition, Reporting, and Investigation Policy and Procedure dated February 2010 was reviewed on 09/26/11 at 11 a.m. indicated, "... All abuse allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative (sponsor, responsible party) within 24 hours of the report. Failure to report will result in disciplinary action, up to and including immediate termination...."			

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	This federal deficiency is related to Complaint IN00097362. 3.1-28(a)			